MedStar National Rehabilitation Network

Submit

CONSENT FOR MEDICAL TREATMENT, INSURANCE AUTHORIZATION, FINANCIAL AGREEMENT AND ACKNOWLEDGEMENT

Patient: DOB:

EMPI: MRN:

Please read carefully before you sign. Your signature acknowledges understanding of all items set forth herein. If you have questions regarding any sections, please ask the assigned outpatient representative for assistance.

1. **General Consent for Treatment:** Voluntarily consent to and authorize care and treatment by the personnel of this center and members of its staff, as deemed necessary, appropriate or advisable in their professional judgment. I acknowledge that no guarantees have been made regarding the effect of such treatment on any medical conditions. I understand that I have the right to make informed decisions regarding all care and treatment, and that I should ask my healthcare professional to further clarify or explain anything I do not understand. This right includes the right to refuse any treatment that I do not want.

2. **Insurance Authorization and Assignment:** Authorize and assign all claims for and payments of any insurance benefits, workers' compensation benefits, government agency and proceeds of any settlements, judgments or verdicts from third party liability claims for injuries treated by the MedStar National Rehabilitation Network ("MNRN") to the MedStar National Rehabilitation Network in an amount equal to the outstanding balance of all charges due and owing.

3. **Financial Agreement/Guarantee of Payment:** I agree that any excess payments may be applied by the MedStar National Rehabilitation Network to satisfy any outstanding accounts resulting from prior treatments. As the patient, responsible party, or guarantor of payment for patient, I agree to be responsible for all charges not covered by the patient's insurance coverage or other claims. I further agree that in the event payment is not made in full for all MNRN charges, that to the extent permitted by applicable law, I shall pay all MNRN costs of collections including reasonable attorney's fees and/or collection agency fees. I understand that verification is never a guarantee of payment. I am responsible for payment of all co-pays at the time of service and that these estimates may be higher than those for my primary care physician.

4. **Acknowledgement of Receipt of Notice of Privacy Practices:** Acknowledge that I have received or declined the MedStar Health Notice of Privacy Practices and Patient Rights and Responsibilities, which include information regarding how to file a grievance.

I certify that 1) I understand the contents of this form and 2) all the information given to the MedStar National Rehabilitation Network inclusive of insurance information is accurate and correct. A photocopy shall be valid as the original.

	7/23/2015	
Signature (Seal)	Date	Time
Patient Name (Please Print)	Witness	
	7/23/2015	
Authorized Person's Signature	Date	Time
Relationship to Patient		

Reason patient unable to sign (check one): Minor ☐ Condition ☐